
Notice of Independent Medical Review Determination

Dated: 10/15/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/10/2013
Date of Injury:	5/15/2006
IMR Application Received:	7/22/2013
MAXIMUS Case Number:	CM13-0002424

- 1) MAXIMUS Federal Services, Inc. has determined the request for continued pain management **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for continued pain management **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The Expert Reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review dated 7/10/2013.

The request for authorization of medical treatment indicates a diagnosis of status post rotator cuff tear. The June 26, 2013, progress report indicates ongoing complaints of left shoulder pain, which continue to worsen. It was noted that the shoulder was treated with surgery, including a rotator cuff repair and subacromial decompression in August 2008, physical therapy, and injections. Left shoulder flexion was reported as 140 degrees, external rotation 45 degrees, and abduction 90 degrees. There was significant pain to palpation over the acromioclavicular joint. The request is for continuing pain management. However, there is no discussion as to the outcome, efficacy, improvement, or success of the pain management that has been completed. As there is insufficient clinical information to support the request for continued pain management, the request is recommended for non-certification.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review (dated 7/22/2013)
- Utilization Review Determination from [REDACTED] (dated 7/10/2013)
- Medical Treatment Utilization Schedule (MTUS)

NOTE: Medical records were not submitted for review in this case.

1) Regarding the request for continued pain management:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9, Table 2), which is part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Chronic Pain Medical Treatment Guidelines, (2009), pages 30-32, which are part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 5/15/2006 and the utilization review determination states that the request for authorization indicates a diagnosis of status post rotator cuff tear. There were no medical records submitted for review in this case. There are no records of past treatments or regimen and there are no future goals or programs provided for review. According to the limited information contained in the utilization review determination letter, there appears to be a flare-up of shoulder pain. However, the request does not specify if it refers to a pain management specialist consultation or a chronic pain program such as functional restoration. The documentation does not support the request. The request for continued pain management is not medically necessary and appropriate.

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/sab

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.